



Commonwealth of Massachusetts
Division of Professional Licensure
Board of State Board of Examiners of Plumbers and Gas Fitters
1000 Washington Street • Boston • Massachusetts • 02118-6100

REQUEST FOR WAIVER OF CONTINUING EDUCATION DEADLINE

This form is required for all licensees seeking a waiver from continuing education due to illness, disability, or other medically-related conditions.

PLEASE PRINT CLEARLY

To be filled out by the Licensee (unless physically unable to, see below)

Last Name:		First Name:		Middle Initial:
Street Address:		City/Town		Zip Code
Phone:	Cell Phone:	email:		
Date of Birth:				
License Numbers →	Journeyman Plumber	Master Plumber	Journeyman Gas Fitter	Master Gas Fitter
ALL OF THE FOLLOWING ITEMS MUST BE INITIALED. IF LEFT BLANK, THE FORM WILL BE DEEMED INCOMPLETE AND WILL NOT BE ACCEPTED.				
1. I have read and understand the continuing education ("CE") requirements contained in 248 CMR 11.04 and understand that, absent a waiver from the Board, I must complete these requirements as a condition of license renewal.				INITIAL BELOW
2. Unless I am permanently disabled, I understand that the Board will grant me a waiver of the <u>deadline</u> to complete the CE requirement and that I will ultimately have to complete the CE.				INITIAL BELOW
3. I certify that I or an immediate family member have/has suffered an illness, disability, or other medically-related condition which has prevented me from working during the period in which I otherwise would have obtained CE.				INITIAL BELOW
4. I understand that the Board has approved internet and correspondence CE courses and certify that, due to the situation that has prevented me from working, I was still unable to complete the CE.				INITIAL BELOW
5. I understand that I will only be eligible for the waiver of CE deadlines if I can provide documentation from a licensed medical physician stating the nature of my medical condition (or that of an immediate family member) and the correlation between that condition and circumstance and my inability to complete the required CE within the required period. That documentation has been included with this form.				INITIAL BELOW
6. I understand that this waiver request does not apply to inspector continuing education.				INITIAL BELOW
7. I understand my request for a waiver is not granted unless I am issued it by the Board in writing.				INITIAL BELOW

CONTINUED ON NEXT PAGE



PLEASE FILL OUT THE FOLLOWING INFORMATION

PLEASE PRINT CLEARLY

Date circumstance/situation began:	Date circumstance/situation ended (or "ongoing" if applicable):
Who suffered the illness, disability, or other medically-related condition(s) (check one): <input type="checkbox"/> Self <input type="checkbox"/> Immediate Family (provide name and relationship):	
Describe in detail the circumstance/situation necessitating a waiver of continuing education deadlines, including why you were unable to work due to said circumstance/situation:	
Name of licensed medical physician providing certification:	
Check here if permanently disabled: <input type="checkbox"/>	At the earliest, when would you be able to complete your CE if given this waiver (insert date):

I certify, under pains and penalties of perjury, that the information on this form is true and accurate.

Signature of Applicant _____ **Date:** _____

If this form was not filled out by the licensee, please print the name and relationship of the applicant to the licensee below. If the authority to sign this document comes from a power of attorney, court order, or other legal process, please attach a copy of that authority.

Name of Applicant _____ Relationship to Licensee _____

NOTE: Requests which do not include the medical certification referred to in #5, above, will be deemed incomplete and will not be accepted.